Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 5-30-01 through 11-7-01.

   b. The request was received on 3-8-02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFAs
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. EOB
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 5-17-02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 5-20-02. The response from the insurance carrier was received in the Division on 5-31-02 Based on 133.307 (i) the insurance carrier's response is timely

4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Statement of Disputed Issues, no date:
   "1) We are requesting to be paid for DOS 5-30-01 thru 11-07-01 for the fee amount of $468.00.
   2) Services were denied as documentation does not support services billed.

3) On our office visits we agreed to correct & down code from 99215 to 99214, and we resubmitted as a corrected reconsideration even after that we were denied again for this level same denial."

2. Respondent: Letter dated 5-30-02:
"99214-CPT code 99214 is defined in the 04/01/96 TWCC Medical Fee Guideline, page 20, as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of theses three key components; a detailed history; a detailed examination; medical decision making of moderate complexity. … **A. The requester did not document the medical necessity for performing an expanded problem focused history at each of the visits in dispute for a patient the requester began treating on 12/06/00**…**B. The requester did not document a detailed physical examination."**… **C. The requester did not document medical decision making of moderate complexity."** … **D. The requester was reimbursed for the 09/05/01 x-ray.**"

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 5-30-01 and extending through 11-07-01.

2. EOB dated 3-8-02 reflects a recommended payment of CPT Code 73560, in the amount of $42.00, for date of service 9-5-01. This code will be addressed in the Dismissal section of this Finding and Decision.

3. The Carrier has denied the disputed charges as reflected on the EOBs as, "COD1 – F,T,N DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER BILLING CODE'S VALUE PER RULE 133.301 (B). A REVISED CPT CODE OR DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED"; "COPY – F – RULE 133.1 REQUIRES THE SUBMISSION OF LEGIBLE SUPPORTING DOCUMENTATION, THEREFORE, REIMBURSEMENT IS DENIED."

Reaudit "Reimbursement is denied for the service billed as the documentation submitted does not support the specific level of service billed as it is defined in the 1996 TWCC Medical Fee Guideline. Rule 133.301 prohibits carriers from reimbursing a service at another billing code's value therefore no reimbursement can be recommended for the service billed in comparison with the documentation. Please submit a revised CPT code or any additional documentation which may support the service billed."

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
5-30-01 7-16-01 8-8-01 9-5-01 10-10-01 11-7-01	99214 99214 99214 99214 99214 99214	$130.00 $130.00 $130.00 $130.00 $130.00 $85.00	$-0- $-0- $-0- $-0- $-0- $-0-	COD1 T,F,N COD1 T,F,N COD1 T,F,N COD1 T,F,N COD1 T,F,N COD1 T,F,N	$71.00	MFG; Evaluation and Management (VI) (B); LETG; (2) (3); Rule 133.304 (c); CPT Descriptor	The Carrier has denied the disputed charges as "COD1 T,F,N". In regard to the "F" and N" denial codes., the office visits reviewed for the disputed dates of service were supportive of two of the required components for CPT Code 99214. The notes were descriptive of a detailed office visit with decision making of moderate complexity. There is no requirement on what verbiage or context the provider must include in each office visit. The only requirement of this code is that the minimum components be met. In regard to the denial code of "T", the carrier has not expounded on the "T" denial. TWCC Rule 133.304 (c) states, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." The Carrier has not provided sufficient explanation of their denial of "T", as required by Rule 133.304 (c). Therefore, reimbursement is recommended in the amount of **$426.00**. ($71.00 x 6 = $426.00)
Totals		$780.00	$42.00				The Requestor is entitled to reimbursement in the amount of **$426.00**

V. Dismissal

Date of service 9-5-01 CPT Code 73560 is being dismissed. According to Commission Rule 133.307 (m), the Division may dismiss a request if: "The requestor informs the commission, or the commission otherwise determines, that the dispute no longer exists".

On 3-8-02 an EOB was issued reflecting a recommended payment of $42.00 for CPT Code 73560, DOS 9-5-01.

Therefore, it is the conclusion of the Medical Review Division that CPT Code 73560 for date of service 9-5-01 be dismissed without any additional action being taken.

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$426.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 9th day of October 2002.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll